Cultural Consultation: A Model of Mental Health Service for Multicultural Societies

Laurence J Kirmayer, MD[1], Danielle Groleau, PhD[2], Jaswant Guzder, MD[3], Caminee Blake, PhD[4], Eric Jarvis, MD, MSc[5]

Objectives: This paper reports results from the evaluation of a cultural consultation service (CCS) for mental health practitioners and primary care clinicians. The service was designed to improve the delivery of mental health services in mainstream settings for a culturally diverse urban population including immigrants, refugees, and ethnocultural minority groups. Cultural consultations were based on an expanded version of the DSM-IV cultural formulation and made use of cultural consultants and culture brokers.

Methods: We documented the service development process through participant observation. We systematically evaluated the first 100 cases referred to the service to establish the reasons for consultation, the types of cultural formulations and recommendations, and the consultation outcome in terms of the referring clinician's satisfaction and recommendation concordance.

Results: Cases seen by the CCS clearly demonstrated the impact of cultural misunderstandings: incomplete assessments, incorrect diagnoses, inadequate or inappropriate treatment, and failed treatment alliances. Clinicians referring patients to the service reported high rates of satisfaction with the consultations, but many indicated a need for long-term follow-up.

Conclusion: The cultural consultation model effectively supplements existing services to improve diagnostic assessment and treatment for a culturally diverse urban population. Clinicians need training in working with interpreters and culture brokers.

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Clinical Implications

- Language barriers and cultural complexity prevent adequate diagnosis and treatment for a significant number of patients, including refugees, new immigrants, and members of established ethnocultural communities.
- A cultural consultation service can respond to these needs in most cases. Assessments, treatment plans, and interventions are well received by referring clinicians.
- There is a need to train clinicians systematically in the effective use of interpreters, culture brokers, and the cultural formulation.

Limitations

- The small number of cases does not permit analysis by ethnocultural group or type of problem.
- There is no direct measurement of patient outcome or cost effectiveness.
- Cultural consultation requires substantial human resources, which may not be available in every setting.

Key Words: culture, ethnicity, immigrants, refugees, cultural formulation, consultation-liaison psychiatry, primary care, mental health services, interpreters, training

Culture shapes the experience and expression of emotional distress and social problems in myriad ways (1,2). To accurately diagnose and treat patients from diverse back-

grounds, therefore, it is essential to consider the cultural meaning of symptoms and explore the social context of distress (3–6). Various models have been developed to meet this clinical challenge. These range from ethnospecific mental health services or clinics (7–9) to the use of specially trained mental health translators and culture brokers and the training of clinicians in generic approaches to cultural competence (10,11). Despite the apparent utility of many of these approaches, there have to date been few studies that examine their effectiveness (12). In a climate of constrained resources for health care and steadily increasing cultural diversity, the development and evaluation of models of care has become an urgent priority.

In many settings, the high degree of population diversity precludes the development of ethnospecific services. Hence, the emphasis is on general strategies combined with resources mobilized for a specific patient. At the same time, there has been a broad movement toward refining the delivery of mental health care in primary care settings (13–16). These considerations suggest the potential value of the consultation-liaison model as a mechanism to address the impact of cultural diversity on mental health problems.

In 1999, with a grant from Health Canada's Health Transitions Fund, we undertook to develop and evaluate a specialized cultural consultation service (CCS) in mental health for the Montreal region. The CCS, based at Sir Mortimer B Davis —Jewish General Hospital, used a consultation-liaison model and emphasized integrating medical anthropology perspectives with conventional psychiatric, cognitive-behavioural, and family systems perspectives.

Although this was a specialized service, it aimed to work within the broader structure of the health care system and to collaborate with existing services in mental health, psychiatry, and primary care. This objective reflects the values of Canadian multiculturalism, which aims to recognize and respond to cultural diversity within mainstream institutions (17–19). In this paper, we summarize some of the lessons learned from our initial evaluation of the CCS.

The Practice of Cultural Consultation

Cultural consultations took 1 of 3 forms:

1. A consultant with relevant cultural expertise directly assessed the patient, preferably with the participation of the referring person. A complete assessment usually involved 1 to 3 meetings with the patient, a brief written report and phone call or case conference to transmit immediate recommendations, and subsequent preparation of a more detailed consultation report.

2. The cultural consultant discussed the case with the referring clinician without seeing the patient directly. In some instances, clinicians presented the case and their questions and concerns during a clinical conference, at which time the CCS team members and invited consultants discussed the issues and made recommendations.

3. CCS consultants met with a referring community organization, without directly seeing community members. Typically, during a clinical conference, community organization representatives presented recurring problems, questions, and concerns they encountered while serving a specific cultural community. The CCS team members and invited consultants then discussed the issues and made recommendations.

Three case vignettes will give an impression of the type of issues dealt with in cultural consultation (Note 1).

Case Report 1

A 21-year-old, recently married woman, newly arrived from India, was referred by an inpatient psychiatry team for anorexia nervosa and somatization unresponsive to treatment. The staff wondered whether they should stop visits from her mother, who was her only surviving relative and who brought food daily, because the girl seemed immature and "enmeshed." During a series of consultation visits from a Hindi-speaking psychologist (conducted both with and without the presence of the referring team), it became clear that the girl was suffering from an undiagnosed medical problem that was duly investigated. Her physical pain was complicated by her distress over the fact that her new husband had absconded to another province after achieving immigration status. Further, he had kept a large dowry given by her mother, who came from a high-status family in her country of origin but who was now a factory worker. The consultation focused on supporting mother and daughter in dealing with multiple stressors that included feelings of shame and family dishonour. Identifying and explicitly acknowledging the social and cultural contexts of her distress allowed the inpatient treatment team to focus on treating the patient's depression, on managing her pain, and on addressing the medical etiology of her somatic symptoms. Her mother's continued support, manifested through the preparation of special foods, was acknowledged as important for her recovery.

Case Report 2

A 22-year-old man from the Caribbean, single and living with his parents, had a diagnosis of brief psychotic episode with symptoms of depression and anxiety. His family had decided to discontinue his neuroleptic medication and take him to the Caribbean to see a folk healer, and he was referred by his outpatient psychiatrist for assessment of treatment noncompliance. The referring psychiatrist adamantly opposed the family's plan and feared that the patient would rapidly decompensate if taken off medication. The CCS arranged

meetings with a psychologist from the Caribbean to allow the family to discuss their concerns. The family attributed the patient's problem to tremendous pressures he had experienced through his involvement in a new religion that he had joined because of a girlfriend. They were not completely opposed to medication but hoped that traditional healing might help their son's condition and that his extended family in the Caribbean would provide him with a safe environment and close supervision. After consultation, the referring psychiatrist was advised to adopt a more flexible position that allowed the family some control over treatment choice. The family agreed to have medication available for their son during the trip, should his condition deteriorate. The patient went to his country of origin and, following treatment by a healer, was greatly improved. His family maintained a strong alliance with the psychiatrist, marked by increased trust and willingness to return if their son's symptoms recurred.

Case Report 3

A 50-year-old married man, a South Asian refugee claimant who had fled police torture without his family, was referred by his family practitioner and refugee clinic team, who were having difficulty understanding him and found him noncompliant with treatment. After 10 months of contacts, they remained unclear about his diagnosis. Further, the patient's lawyer had missed the first hearing before the Immigration Review Board, resulting in a delay for his claim and subsequent deterioration in his condition. He related this story through an interpreter, apologizing repeatedly for his disorientation and memory lapses. He described chronic anxiety, insomnia, recurrent nightmares, and suicidal ideation. He wept as he spoke of the chronic pain and other symptoms he had experienced as sequelae of torture. He felt that his value as a man had been undermined because he had left his family behind to face an uncertain fate. Following the consultation, his antidepressant medication was increased and the issue of adherence to treatment was addressed by mobilizing additional support, including increased contact with a social worker, phone-call reminders, and the participation of religious leaders. The consultant reframed the patient's predicament in the context of his strong spiritual and religious values, and his abandonment of the family was discussed as a choice that required the courage to take risks to safeguard his family's future. As his attention was shifted to hope for his children and his own spiritual life, this patient was able to mobilize a more resilient response. The consultant first worked with the referring team alone, to discuss the case, and later with the patient present, to bridge the cultural barriers to understanding. A summary of the consultation was sent to the patient's lawyer to support his upcoming refugee hearing.

These cases illustrate some of the complex issues addressed in cultural consultations. The CCS used a team of consultants with expertise in cultural psychiatry, as well as interpreters and culture brokers. This approach allowed the CCS to address the interplay of social, cultural, and systemic factors to produce more accurate diagnoses and to negotiate treatment plans that made sense to patients and to referring clinicians.

Service Development and Evaluation

We documented the process of setting up the service through periodic research meetings and semistructured interviews of key staff undertaken by a medical anthropologist. We also used various quantitative and qualitative methods to evaluate the first 100 cases seen. Quantitative evaluation of the service involved assessing the outcome of consultations in terms of the following: 1) types of cases referred and evaluated, 2) use of specific professional and community resources, 3) types of interventions and recommendations, 4) the consulting clinician's satisfaction of with the service, and 5) the consulting clinician's concordance with the recommended interventions. The qualitative component of the evaluation employed a participatory research model involving participant observation by a research anthropologist working in close collaboration with the team (20). We used a protocol to summarize case conferences and to interview both consultees and consultants. The following elements were documented: 1) the type of intercultural problems referred to the CCS, 2) the types of persons and institutions who use the CCS, 3) the types of cultural formulations and their influence on interventions, 4) the types of clinical and community recommendations proposed, 5) barriers to service implementation and how they were overcome, and 6) intrinsic and extrinsic factors that hindered or facilitated the implementation of CCS recommendations.

Service Development

The CCS was designed and implemented to provide the following: specific cultural information, links to community resources or to formal cultural psychiatric or psychological assessment, and recommendations for treatment. Referrals were accepted from health practitioners, community workers, schools, and other institutions—but only for patients that already had an identified primary care provider or case manager.

Core CCS personnel included 2 part-time psychiatrists, as well as psychologists, social workers, psychiatric nurses, medical anthropologists, and trainees from these disciplines and from family medicine. A full-time clinical psychologist acted as clinical coordinator and triaged all referred cases. The psychologist interviewed referring clinicians to determine the reasons for consultation and to identify the resource persons

needed to conduct the evaluation (for example, interpreters, culture brokers, or clinicians with specific skills).

Two computerized databases were developed to facilitate the work. The first comprised available cultural consultants and culture brokers with specific linguistic, cultural, or clinical skills; the second listed community organizations and resources for specific ethnocultural communities or groups (such as refugees or people seeking asylum). The databases updated and expanded existing listings previously developed by the Multiculturalism Program and the Transcultural Child Psychiatry Service at the Montreal Children's Hospital.

We prepared a handbook to guide consultants through the consultation process. Consultants were asked to use the "Outline for Cultural Formulation" in DSM-IV (21–23); an expanded version of the cultural formulation was prepared that emphasized issues related to migration, ethnic identity, family systems, and developmental issues.

We distributed a brochure describing the service and providing contact information to all registered psychiatrists and psychologists in the province of Quebec. Presentations to regional clinics and departments of psychiatry by CCS team members also increased awareness of the service and led to subsequent referrals. However, most clinicians requesting consultations had heard about the service through word of mouth.

We discussed cases during a weekly case conference. At that time, additional expertise could be brought in to assist with formulating the cultural dimensions of each case. This conference served as a training setting, built team cohesion, and provided an opportunity for quality control, in that the skill level and orientation of new consultants could be judged from the quality of their clinical presentation. A research anthropologist was a participant observer at the clinical case conferences and met subsequently with clinical staff to qualitatively evaluate the service.

Characteristics of Consultations

Over the initial 12-month period of operation, the CCS received 102 requests for consultation. Referrals came from the whole range of health and social service professionals based at hospitals, community clinics, and private offices. While most consultation requests concerned individuals, almost one-third involved couples. About 60% were women, 44% had only elementary school education, 9% had high school education, 47% had some college or university education, 65% were unemployed, 27% were Canadian citizens, 24% were landed immigrants, and 41% were refugees or asylum seekers. Four cases involved requests from organizations to discuss issues related to their work with a whole ethnocultural group or community.

At the time of initial contact, the most commonly stated reasons for consultation were as follows: requests for help in clarifying a diagnosis or the meaning of specific symptoms or behaviours (58%), requests for help in treatment planning (45%), and requests for information or a link to organizations and resources related to a specific ethnocultural group or issue (for example, refugee status) (25%). One-half of all cases had multiple reasons for requesting consultation, which gives some indication of the complexity and interrelatedness of the issues.

The cases represented enormous cultural diversity, with 42 countries of origin, 28 languages, over 50 ethnocultural groups, 6 major religious traditions, and numerous distinct sects. This demanded a wide range of consultants, interpreters, and culture brokers. The bank of culture brokers and consultants included 73 professionals, who were predominately psychologists, psychiatrists, and social workers. A few consultants were used repeatedly, both because of the specific background of the referred cases and because of their high level of skill.

Almost one-half of all requests to the CCS (50 cases) were resolved with telephone contact and either informal exchange of information or linking to specific resources. In about 20% of the cases, the clinical coordinator felt that there was no need for a cultural consultation. Some of these cases represented inappropriate referrals for which basic medical and social services had not yet been arranged; others involved an effort to refer a difficult case with no apparent cultural component, in the hope of obtaining additional services. In 10 of the 52 cases for which a consultation was recommended, the consultation occurred entirely through discussion with the referring clinician, and the patient was not seen.

Interpreters were needed for about one-half of all consultations. In many cases, we met this need with a clinician who spoke the requisite language. In two-thirds of the cases, it was necessary to match the consultants' background in some way with that of the patient (for example, in language, ethnicity, or religion). In one-third of the cases, some specific clinical skills were needed (for example, psychiatric expertise; family therapy training; or experience working with trauma, refugees, or somatization).

While it was possible to find appropriate consultation resources in most cases, ethnic matching was very approximate. Often, it was not possible to find a clinician with the requisite language skills and cultural knowledge to address specific cultural and mental health issues. In such cases, we used an interpreter or cultural broker and a clinician with generic expertise in cultural consultation. However, it was difficult to find well-trained interpreters or appropriate culture brokers to work with patients or families from some of the smaller

ethnocultural communities or with more recent immigrants. Further, ethnic matching was sometimes contraindicated. For example, patients were sometimes reluctant to meet with a culture broker or consultant from their own background when the small size or internal milieu of the local community made confidentiality a concern.

Cultural Formulations

In cultural consultations, we raised a wide range of issues to provide the social, cultural, and political context for patient symptoms and behaviour and to guide diagnostic assessment, treatment planning, and service delivery. Attention was given to the patients' cultures of origin and to their social circumstances (for example, poverty, unemployment, and experience of racism). When formulating cultural issues, we avoided sweeping generalizations or cultural stereotypes and focused on detailed histories and local cultural issues that could be explicitly linked with the patients' symptoms and distress. We also emphasized the culture of psychiatry and the health care system in general—the values, models, assumptions, and institutional practices that may diverge from patient expectations and create misunderstandings, interactional problems, or conflicts that are sometimes mistakenly attributed to a patient's cultural or personal background.

The most frequently raised issues were as follows:

- variations in family systems, including structure, roles, and value systems (for example, patriarchal families) (24,25)
- identity issues related to age and gender roles and life-cycle transitions (for example, the significance for identity and social status of marriage, divorce, child-bearing, adolescence, or being an elder) (26–30)
- the impact of exposure to torture, war, and organized violence in political and historical context (31,32)
- for asylum seekers, the profoundly stressful impact of the refugee claimant process, with its prolonged period of uncertainty and review board hearing (33,34)
- the intergenerational impact of migration (for example, issues of identity, the fracturing of extended families, changing gender roles, the loss of communal supports and mediators, and the creation of tensions between generations) (35,36)
- the effects of subtle or covert racism or other biases on provision of services to patients (5,37–41)
- the prevalence of dissociative and somatoform symptoms, leading to misdiagnoses of psychosis, personality disorder, or malingering (42,43)
- previous experiences with health care and healing practices in the country of origin, including biomedicine and traditional systems of medicine (44,45)
- the importance of religious practices for coping and social support, particularly in the psychological containment of grief and anxiety (46,47)

Interestingly, explanatory models of illness, which form a large part of the literature in medical anthropology, were not central to most of the case formulations. It appeared that many individuals had pluralistic models that enabled them to make use of both biomedical and traditional resources. Difficulties arose because of conflicts with clinicians who were intent on pursuing a single course of action, with little tolerance for patients' medical pluralism. Of course, it is possible that distressed individuals who understood their problems exclusively in terms of traditional explanatory models were less likely to make use of biomedical health care services and hence, less likely to be referred to the CCS.

Recommendations

The most common recommendations emerging from the cultural consultation involved reassessing or changing treatment (70%) or using an additional treatment (for example, medication or psychotherapy) (48%). A change in diagnosis was recommended in 23% of cases. In 9 cases, it was suggested that treatment be reorganized to enable ethnic match at the level of clinician, service, or specific type of treatment intervention.

Outcome

In all, 29 referring clinicians (representing 47 cases) completed service evaluation questionnaires. Of these, 86% reported that they were satisfied with the consultation and that it had helped them manage their patients. Useful aspects of the consultation included increased knowledge of the social, cultural, or religious aspects of their cases (41%); increased knowledge of the psychiatric or psychological aspects of their cases (21%); improved treatment (48%); improved communication, empathy, understanding, or therapeutic alliance (31%); and increased confidence in diagnosis or treatment (14%). The major difficulties or dissatisfactions with the cultural consultation were the lack of treatment or more intensive follow-up (14%), unavailability or inappropriateness of recommended resources (14%), concerns about the competence of the culture broker (10%), and the impression that there was too much focus on social context, rather than on psychiatric issues (10%). All said they would use the service again and would recommend that their colleagues use it. They reported high rates of concordance with recommendations. In 21 cases, some aspect of the CCS recommendations was not implemented. Reasons for this included patient noncompliance ($n =$ 13), lack of staff or other resources ($n = 9$), and spontaneous improvement ($n = 7$).

Lessons Learned

The cases referred to the CCS revealed that language barriers and the cultural complexity of assessing symptoms prevented adequate diagnosis and treatment for a significant number of patients, including refugees, new immigrants, and members of established ethnocultural communities. The CCS was able to respond to these needs in most cases, and the subsequent assessments, treatment plans, and interventions were well received by referring clinicians.

Consultations required substantial resources in terms of specific expertise in cultural psychiatry, interpreters, and culture brokers. Evaluations often involved teams of 2 to 3 clinicians, interpreters, and culture brokers, as well as multiple or lengthy contacts with patients and their families. However, the result of this intensive process was often a change in diagnosis and treatment plan, with significant immediate and long-term consequences for patient functioning, decreased use of services, and increased clinician satisfaction.

Cultural consultation often facilitated the therapeutic alliance between the referring person and the patient. This positive change frequently started to express itself when the consulting clinician was present during the clinical interview carried out by the culture broker. Perhaps the clinician's effort to seek a consultation demonstrated to the patient an interest in understanding the patient in his or her own cultural framework. The cultural formulation produced by the consultation placed the patient's puzzling or disturbing symptoms and behaviours in a social and cultural context and thus made sense of them. By clarifying the patient's predicament, the consultation increased the clinician's empathy. In recognition of this, the CCS team on most occasions invited all consulting clinicians to be present during the cultural broker's clinical interview, to facilitate knowledge transfer and strengthen the clinical alliance.

Cultural consultation also revealed a case's complexity and often transformed the clinician's frustration or feeling of being overwhelmed into an appreciation of the intellectual and professional challenge presented, leading to increased clinician interest and motivation to remain actively involved. Even when patients were not seen, the advice and reinterpretation of events provided by the CCS team worked to improve and maintain the referring clinician's treatment alliance and refine the diagnostic and treatment approach.

Evaluation of the cases referred to the CCS identified important systemic barriers to the use of interpreters within medical institutions. Clinicians were untrained in their use and not compensated for the added time and effort required. Because clinicians did not know that interpreters were both important and available, there was a lack of demand for interpreter services. Administrators, too, were unaware that a pool of available interpreters had been established by the regional health authority (48).

Challenges to Service Implementation

We faced several challenges in the process of conducting cultural consultations, which raises important considerations for the future development of this type of service.

While some clients welcomed the opportunity to be seen by a clinician or culture broker from a similar cultural background, other clients expressed reservations or concerns that being seen by someone from their own community might compromise their privacy. These concerns were realistic for patients from some small cultural communities with high degrees of stigmatization of mental health problems. Reassuring patients about rules of confidentiality was necessary but not always sufficient. The concerns about confidentiality also applied to the use of interpreters during the consultation. Similarly, some clients who were seeking asylum expressed concern about how information gathered during a cultural consultation might affect their application for refugee status.

A shared body of knowledge and experience is crucial to clinicians' ability to understand and empathize with their patients' predicaments. For clinicians to appreciate these patients' problems and begin to think more clearly about assessment and intervention, it was essential to introduce some of the rich and complex social and cultural context of their lives. At times, however, the complexity of the formulation had the potential to undermine the referring clinician's competence and confidence. It was crucial to the success of the consultation that clinicians came to view the cultural dimensions as understandable and within their sphere of competence. Accordingly, it was essential to devise formulations that did not simply elaborate the complexity and ambiguity of the case but yielded pragmatic guidelines for intervention. Models drawn from family therapy and cognitive-behavioural therapy provided useful bridges from specific social and cultural formulations to clinicians' existing domains of expertise.

Clinicians often made demands of the CCS that went beyond consultation to include requests for emergency intervention, for comprehensive primary care, or for transfer of the patient for long-term treatment or case management. This may reflect not only the additional challenge posed by cultural difference but also the limited resources for mental health treatment available in the health care system as a whole. In several consultations, the referring clinician became inaccessible or stopped treating the patient, presumably on the assumption that the CCS would become responsible for the patient's subsequent care. In some cases, when there was a clear need for long-term intervention and a good match of skills, the CCS staff or consultants did undertake ongoing treatment or

continued to work as culture brokers. Mechanisms must be sought to support such work in a climate of constrained health care services and limited coverage of refugee claimants.

CCS staff benefited from a cohesive team that could absorb the impact of stories of massive trauma, conflicts of cultural values, diagnostic uncertainty, and limits of professional competence. However, cultural consultants or culture brokers were sometimes placed in difficult and opposing positions when called upon to balance the demands of developing an alliance with the patient based on cultural understanding while still negotiating the rules, norms, and standards of traditional psychiatric care. It was therefore fundamental to the consultation's success that the consultant possess a high level of interpersonal skill.

The CCS actively promoted the use of professional interpreters in hospital and other mental health settings. The recommendation to use an interpreter was frequently made as part of a consultation but also as a phone intervention, even when a consultation was not pursued. Despite this, resistance to the use of interpreters persisted, with hospitals relying on family or housekeeping staff to interpret and using only a fraction of the budget allotted for interpreters by the regional health authority (48).

Conclusion: Implications for Training, Policy, and Research

Our experiences with the CCS have implications for training, health policy, and research. There is a need to increase awareness of cultural issues in mental health and corresponding clinical skills among primary care clinicians and social service workers, through in-service training. Specialized cultural consultation services can play a major role in educating clinicians and in developing innovative intervention strategies that can later be transferred to practitioners in primary care settings. The multiple perspectives, skills, and backgrounds represented in a culturally and professionally diverse team can facilitate critical analysis of conventional practices and case formulation and lead to creative intervention. This diversity can also sustain a cohesive, collegial group able to support consultants' efforts to challenge systemic problems, including institutional racism.

There is a need to strengthen the training of mental health practitioners in concepts of culture and strategies for intercultural care (49). This training should recognize the value of clinicians' own linguistic and cultural knowledge as added skills. There is a particular need to train mental health practitioners to work with interpreters (50). This should become standard, not only in graduate training programs in psychology, psychiatry, and family medicine residencies but also in the education of other mental health and social service professionals.

In turn, there is a need for additional training of interpreters to increase their expertise in mental health. Interpreters also need ongoing supervision and support to work with

potentially distressing or traumatizing situations (51). The role of interpreter is insufficient to address the exploration of cultural context and meaning essential for a cultural formulation. Consequently, there is also a need to develop the role of culture brokers, who can work closely with clinicians to mediate during clinical encounters (52). Culture brokers require formal training in mental health (53), ongoing supervision, development of formal assessment of competence, and a mechanism for remuneration. In parallel with this professional development, there is a need to support community services and to improve liaison with other mental health care professionals, so that appropriate resources to assist with the social care of patients can be identified.

The cases seen by the CCS clearly demonstrated the impact of cultural misunderstandings: incomplete assessments, incorrect diagnoses, inadequate or inappropriate treatment, and failed treatment alliances. These problems are costly, both in terms of increased service use and in terms of poor clinical outcomes. Directly measuring patient outcome would allow a more robust test of the value of the consultation service; however, there are many practical barriers to such an evaluation. For example, the diversity of the cases in terms of sociodemographic characteristics, diagnostic categories, and type of consultation request would require different measures of successful outcome. In addition, any measures would need to be translated into many languages and standardized for the patients' variable level of education. Further, many consultations did not involve direct contact with patients and exerted their effects only through subsequent changes in the approach of clinicians and social service agencies over an extended period of time, making the timing of any evaluation problematic. Similar obstacles have been identified in efforts to evaluate the cost-effectiveness of psychiatric consultation in general hospitals (54). Some of these difficulties can be surmounted by accruing a larger patient cohort that can be subdivided into more homogeneous groups. In future research, we plan to assess the clinical outcomes and cost-effectiveness of this approach and identify specific clinical strategies useful in the consultative process.

Note

1. Details of the cases have been modified to protect patient anonymity.

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[1] James McGill Professor and Director, Division of Social and Transcultural Psychiatry, McGill University, Montreal, Quebec; Director, Culture and Mental Health Research Unit, Sir Mortimer B Davis—Jewish General Hospital, Montreal, Quebec.

[2] Assistant Professor, Division of Social and Transcultural Psychiatry, McGill University, Montreal, Quebec; Staff investigator, Culture and Mental Health Research Unit, Sir Mortimer B Davis—Jewish General Hospital, Montreal, Quebec.

[3] Associate Professor, Division of Social and Transcultural Psychiatry, McGill University, Montreal, Quebec; Director, Child Day Treatment Centre, Department of Psychiatry, Sir Mortimer B Davis—Jewish General Hospital, Montreal, Quebec.

[4] Postdoctoral Fellow, Division of Social and Transcultural Psychiatry, McGill University, Montreal, Quebec; Former Clincial Coordinator, Cultural Consultation Service, Sir Mortimer B Davis—Jewish General Hospital, Montreal, Quebec.

[5] Faculty Lecturer, Division of Social and Transcultural Psychiatry, McGill University, Montreal, Quebec; Director, Cultural Consultation Service, Sir Mortimer B Davis—Jewish General Hospital, Montreal, Quebec.

Address for correspondence: Dr LJ Kirmayer, Culture and Mental Health Research Unit, Institute of Community and Family Psychiatry, 4333 Côte Ste Catherine Rd, Montreal, QC H3T 1E4

e-mail: laurence.kirmayer@mcgill.ca

Résumé : La consultation culturelle : un modèle de service de santé mentale pour les sociétés multiculturelles

Objectifs : Cet article rend compte des résultats de l'évaluation d'un service de consultation culturelle (SCC) pour les médecins de la santé mentale et les cliniciens des soins primaires. Le service était destiné à améliorer la prestation des services de santé mentale dans les établissements réguliers pour une population urbaine diversifiée sur le plan culturel, comprenant des immigrants, des réfugiés et des groupes ethnoculturels minoritaires. Les consultations culturelles se fondaient sur une version élaborée de la formulation en fonction de la culture du *DSM-IV*, et utilisaient des consultants et des représentants culturels.

Méthodes : Nous avons documenté le processus de développement du service par l'observation des participants. Nous avons évalué systématiquement les 100 premiers cas adressés au service pour établir les raisons de la consultation, les types de formulations culturelles et de recommandations ainsi que le résultat de la consultation en ce qui concerne la satisfaction du médecin traitant et la concordance des recommandations.

Résultats : Les cas vus par le SCC démontraient nettement l'effet des malentendus culturels : des évaluations incomplètes, des diagnostics inexacts, un traitement inadéquat ou non approprié, et l'échec des alliances de traitement. Les cliniciens qui ont adressé des patients au service ont déclaré des taux élevés de satisfaction quant aux consultations, mais nombre d'entre eux ont indiqué un besoin de suivi à long terme des cas.

Conclusion : Le modèle de consultation culturelle supplée efficacement aux services existants pour améliorer l'évaluation diagnostique et les traitements d'une population urbaine aux diverses cultures. Les cliniciens ont besoin d'une formation pour travailler avec des interprètes et des représentants culturels.